Title 24-A: MAINE INSURANCE CODE

Chapter 32: PREFERRED PROVIDER ARRANGEMENT ACT

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§2670. SHORT TITLE

This chapter may be cited as the "Preferred Provider Arrangement Act." [1999, c. 609, §4 (AMD).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §4 (AMD).

§2671. DEFINITIONS

As used in this chapter, unless the context indicates otherwise, the following terms have the following meanings. [1985, c. 704, §4 (NEW).]

1. "Administrator" means any person, other than a carrier, that administers a preferred provider arrangement. An administrator does not include a health maintenance organization licensed pursuant to chapter 56 or a nonprofit health care plan regulated by the superintendent pursuant to Title 24. An employer exempt from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered an administrator.

[1999, c. 609, §5 (AMD) .]

1-A. "Capitation" has the same meaning as defined in section 4331, subsection 2.

[1999, c. 609, §5 (NEW) .]

2.

[1999, c. 609, §5 (RP) .]

2-A. "Carrier" means an insurance company licensed in accordance with this Title, a fraternal benefit society authorized pursuant to chapter 55 or a nonprofit hospital or medical service organization licensed pursuant to Title 24. An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

[1999, c. 609, §5 (NEW) .]

2-B. "Enrollee" means an individual entitled to reimbursement for expenses of health care services under a health plan.

[1999, c. 609, §5 (NEW) .]

3. "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's legal authorization.

[1985, c. 704, §4 (NEW) .]

3-A. "Health plan" means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan.

[1999, c. 609, §5 (NEW) .]

4.

[1999, c. 609, §5 (RP) .]

5.

[1999, c. 609, §5 (RP) .]

6. "Preferred provider" means a provider who enters into a preferred provider arrangement with an administrator or carrier.

[1999, c. 609, §5 (AMD) .]

7. "Preferred provider arrangement" means a contract, agreement or arrangement between a carrier or administrator and a provider in which the provider agrees to provide services to a health plan enrollee whose plan benefits include incentives for the enrollee to use the services of that provider.

[1999, c. 609, §5 (AMD) .]

8. "Provider" means an individual or entity duly licensed or otherwise legally authorized to provide health care services, including, but not limited to, the treatment of physical health and mental health and provision for medical supplies and pharmaceutical supplies.

[1999, c. 609, §5 (AMD) .]

9. "Superintendent" means the Superintendent of Insurance.

[1999, c. 609, §5 (AMD) .]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1995, c. 332, §P1 (AMD). 1999, c. 609, §5 (AMD).

§2672. SELECTIVE CONTRACTING AUTHORIZED

Carriers or administrators may enter into preferred provider arrangements with providers of their choice. In selecting preferred providers, carriers or administrators may consider, among other factors, price differences between or among providers, geographic accessibility, specialization and projected utilization by enrollees. Selective contracting does not constitute unreasonable discrimination against or among providers. [1999, c. 609, §6 (AMD).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §6 (AMD).

§2673. POLICIES, AGREEMENTS OR ARRANGEMENTS WITH INCENTIVES OR LIMITS ON REIMBURSEMENT AUTHORIZED

(REPEALED)

SECTION HISTORY

1985, c. 704, §4 (NEW). 1989, c. 588, §A49 (RPR). 1999, c. 609, §7 (RP).

§2673-A. PREFERRED PROVIDER ARRANGEMENTS

1. **Filing with superintendent; disapproval.** A carrier or administrator who proposes to offer a preferred provider arrangement shall file with the superintendent proposed agreements, rates, geographic service areas, provider networks and other materials relevant to the proposed arrangement. The superintendent shall disapprove any preferred provider arrangement if the arrangement contains any unjust, unfair or inequitable provisions; unreasonably restricts access and availability of health care services; or fails to comply with other requirements of this chapter, chapter 56-A or rules adopted by the superintendent.

[1999, c. 609, §8 (NEW) .]

2. **Considered separate preferred provider arrangements.** If health plans offered by the same carrier have different geographic service areas, or if there are preferred providers in one health plan who are nonpreferred providers in another health plan offered by the same carrier or administered by the same administrator or who are in a different preference tier if the plan is a multitier plan, then the plans represent different preferred provider arrangements and must be separately filed and approved.

[1999, c. 609, §8 (NEW) .]

3. **Rules.** Preferred provider arrangements offered by carriers that are subject to chapter 56-A must be in compliance with applicable provisions of that chapter and any rules adopted under that chapter. Employer-sponsored plans that are exempt from this chapter pursuant to federal law and administrators offering preferred provider arrangements to employer-sponsored plans are not subject to the provisions of chapter 56-A or rules adopted under that chapter, provided either the administrator or any other participating entity, other than the self-insured employer, does not undertake insurance risk. The superintendent may adopt rules establishing procedures for filing and approval of preferred provider arrangements, including the time period within which the superintendent must act on a completed application; specific criteria for determining when a term or condition is unjust, unfair or inequitable or has the effect of unreasonably restricting access and availability to health care services; and standards consistent with this chapter and chapter 56-A for the ongoing operation and oversight of approved provider arrangements. The rules may prohibit the carrier from applying a benefit level differential to enrollees who must travel an unreasonable distance to obtain the service. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

[1999, c. 609, §8 (NEW) .]

SECTION HISTORY
1999, c. 609, §8 (NEW).

§2674. REQUIREMENTS APPLICABLE TO ADMINISTRATORS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §9 (RP).

§2674-A. REQUIREMENTS FOR ADMINISTRATORS AND CARRIERS

1. **Registration fee.** All administrators of a preferred provider arrangement shall register with the superintendent and pay an annual registration fee pursuant to section 601, subsection 20. The superintendent shall by rule establish criteria for the registration, including minimum solvency requirements. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

[1999, c. 609, §10 (NEW) .]

2. **Compilation of current listing.** The bureau shall compile and maintain a current listing of administrators and carriers offering preferred provider arrangements authorized under this chapter.

[1999, c. 609, §10 (NEW) .]

3. **Prohibition against insurance risk.** Except as specifically authorized in section 2676, an administrator may provide administrative services only and may not accept insurance risk.

[1999, c. 609, §10 (NEW) .]

4. **Approval required before marketing or making available.** A carrier may not issue a health plan incorporating a preferred provider arrangement and an administrator may not market or otherwise make available a preferred provider arrangement until the superintendent pursuant to section 2673-A has approved the arrangement.

[1999, c. 609, §10 (NEW) .]

5. **Registration as insurance administrator.** In addition to meeting the requirements of the preferred provider arrangement, each preferred provider administrator who directly or indirectly transfers funds, manages funds, adjusts claims or asserts control over the transfer of funds for the purpose of payment of provider services shall register with the superintendent as an insurance administrator pursuant to chapter 18.

[1999, c. 609, §10 (NEW) .]

6. **Provision of document to beneficiary.** Each preferred provider administrator shall inform all carriers that the carriers must provide to each enrollee of any health plan subject to this chapter a plan description that complies with the requirements of and rules adopted under chapter 56-A, subchapter I.

[1999, c. 609, §10 (NEW) .]

SECTION HISTORY
1999, c. 609, §10 (NEW).

§2675. REQUIREMENTS APPLICABLE TO INSURERS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1989, c. 588, §§A50-52 (AMD). 1999, c. 609, §11 (RP).

§2676. RISK TRANSFER

Preferred provider arrangements may include capitated payments that are limited to the health services provided by the provider. [1999, c. 609, §12 (AMD).]

Preferred provider arrangements may embody risk transfer between carriers and providers in accordance with the provisions of chapter 56-A, subchapter III. Any other acceptance of insurance risk by a person that does not hold a valid certificate of authority or license and is not exempt by law from licensure constitutes the unauthorized transaction of insurance within the meaning of section 404 and chapter 21. [1999, c. 609, §12 (NEW).]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1989, c. 588, §A53 (RPR). 1999, c. 609, §12 (AMD).

§2677. ALTERNATIVE HEALTH CARE BENEFITS

(REPEALED)

SECTION HISTORY
1985, c. 704, §4 (NEW). 1987, c. 34, §2 (AMD). 1989, c. 588, §A54 (RPR). 1993, c. 600, §B19 (AMD). 1999, c. 609, §13 (RP).

§2677-A. PAYMENT FOR NONPREFERRED PROVIDERS

1. **Nonpreferred providers.** A carrier incorporating a preferred provider arrangement into a health plan shall provide for payment of covered health care services rendered by providers that are not preferred providers.

[1999, c. 609, §14 (NEW) .]

2. **Benefit level.** The benefit level differential between services rendered by preferred providers and nonpreferred providers may not exceed 20% of the allowable charge for the service rendered, except that the superintendent may waive this requirement for a given benefit plan. Compliance with this requirement for a given benefit plan may be demonstrated on an aggregate basis. This demonstration of compliance must be based on a reasonably anticipated mix of claims certified by a qualified actuary who is a member of the American Academy of Actuaries or a successor organization. As used in this subsection, "allowable charge" means the amount that would be payable for services under the preferred provider arrangement including deductible and coinsurance amounts.

[2001, c. 369, §3 (AMD) .]

SECTION HISTORY
1999, c. 609, §14 (NEW). 2001, c. 369, §3 (AMD).

§2678. ANNUAL EXPERIENCE REPORT

On or before April 1st of each year, an administrator or carrier who issues or administers a program, policy or contract in this State that includes incentives for the enrollee to use the services of a provider who has entered into an agreement with the carrier or administrator shall file a report of its activities for the preceding year with the superintendent. The report must be in the form prescribed by the superintendent and at a minimum must contain the following: [1999, c. 609, §15 (AMD).]

1. A provider directory that includes the name, address and scope of license of each preferred provider; and

[1999, c. 609, §15 (AMD) .]

2.

[1999, c. 609, §15 (RP) .]

3. Annual information specified in chapter 56-A or rules adopted under that chapter. Annual information reported to the superintendent pursuant to chapter 56-A under another license must be referenced in the report and not reported in a duplicate manner.

[1999, c. 609, §15 (NEW) .]

SECTION HISTORY
1985, c. 704, §4 (NEW). 1999, c. 609, §15 (AMD).

§2678-A. ANNUAL REPORT

(REPEALED)

SECTION HISTORY
1989, c. 588, §A55 (NEW). 1999, c. 609, §16 (RP).

§2679. UTILIZATION REVIEW DATA

(REPEALED)

SECTION HISTORY
1987, c. 168, §3 (NEW). 1999, c. 609, §17 (RP).

§2680. STANDARDIZED CLAIM FORM

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to Title 24, section 2985. [2003, c. 469, Pt. D, §5 (AMD); 2003, c. 469, Pt. D, §9 (AFF).]

SECTION HISTORY
1993, c. 477, §D9 (NEW). 1993, c. 477, §F1 (AFF). 1999, c. 609, §18 (RPR). 2003, c. 218, §5 (AMD). 2003, c. 469, §D5 (AMD). 2003, c. 469, §D9 (AFF).